Surgeon General's Media Update
Oct. 26, 2006

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Opponents of the Pentagon's plan to resume mandatory anthrax vaccinations are acting fast to get the word out on the drug by hosting a day-long seminar in Washington on Saturday.

The Anthrax Continuing Legal Education Seminar will be hosted by Byron Holcomb, a retired Navy judge advocate general and one of the attorneys representing anthrax victims. The seminar will be held at the offices of Holcomb's law firm, Garvey, Schubert and Barer, in Georgetown's Flour Mill Building, 1000 Potomac St. NW.

Lawyers who have worked on three key cases in the battle over the mandatory vaccination program will speak, including Mark Zaid, who represented the six anonymous plaintiffs in the federal Doe v. Rumsfeld case.

But the seminar will not be limited to legal questions. Also speaking will be former service members who say they suffered adverse effects from the anthrax shots and medical professionals, including Dr. Mark Geier, of the Vaccine Adverse Event Reporting System, and anthrax expert Dr. Meryl Nass.

For more information or to attend the conference, contact Kathryn Coulter at (202) 419-3257.

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RUSHDI MULLA **—** The first few were hesitant, coming in by ones and twos, but soon the floodgates opened and the citizens of Rushdi Mullah came from all over town to receive medical care Oct. 19 at a Multi-National Division – Baghdad medical operation.

The medical operation was conducted by soldiers of 2nd Brigade Combat Team, 10th Mountain Division, in the small town of Rushdi Mulla, and was intended mostly to get an idea of what medical supplies were needed and to determine what clinics and health care providers were available in the area.

"It's what we came to do, besides taking care of our own," said Spc. Carrielynn Spillis, a native of Toledo, Ohio, and a medic with Company C, 210th Brigade Support Battalion, attached to 4th Battalion, 31st Infantry Regiment. "It's nice being able to come here and help them."

Kazar, a resident of Rushdi Mullah, brought his cousin's son, Mustafa, to the operation to have the 1-year-old boy's hand treated for an injury.

Medics washed it and applied antibacterial ointment and explained, through an interpreter, that each finger would have to be wrapped separately to keep them from healing together.

"I'm glad the Americans came to help," Kazar said.

"We're planning treatment … to provide for local civilians in the area," said Sgt. Jason Lane, a medic with 4-31 Infantry Regiment. "We had a very good turnout, didn't see anything too extreme, and we have a better idea of what to expect in this area."

“Initially they were fairly timid,” he said. “By the end of the operation, they were more personable, particularly the children.”

The soldiers brought bags of toys – everything from plush animals to squeezable rubber ducks, which seemed to transcend the language barrier and brought smiles.

Initially, the operation was announced over loudspeakers throughout the neighborhood; but after a poor showing to start the operation, soldiers went door-to-door to get the word out.

“When we did the foot patrol with announcements, we saw a huge change (in turnout),” said Maj. Robert Griggs, a native of Colusa, Calif., and plans officer for 4-31 Inf. Regt.

It wasn’t only the medics who made the operation work.
“We went out to distract the enemy so the medics could act,” said Pfc. James Cook, Company D, 4-31 Inf. Regt. “We set up three traffic control points to search vehicles and patrolled the areas … It was all quiet.”

“We kept an eye on things to make sure soldiers didn’t get hurt. We all came back in one piece. It was a good patrol,” said Pfc. Samuel Rhodes, also of Company D.

“It’s a positive step in the war on terror,” said 1st Lt. Aaron Brooks, of Syracuse, N.Y., medical platoon leader, 4-31 Inf. Regt. “The Iraqis trust us enough to seek health care, and we are willing to give it in any way possible. … The end state should be that we help support the Ministry of Health to do its own medical operations.”

More malaria-carrying mosquitoes detected in South Korea
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CAMP RED CLOUD, South Korea — Mosquitoes carrying malaria are far more prevalent in South Korea now than they were at the same time last year because of unusually warm autumn weather, national public health officials said Tuesday.

Workers from the Seoul Research Institute of Public Health and Environment collected 75 mosquitoes carrying malaria from September through the second week of October. Collections in the same area and time last year yielded only 10 malaria-carrying mosquitoes.

“The relatively high temperature of the metropolitan area makes it more susceptible to mosquito breeding,” said Kweon Jun-wook, director of communicable disease surveillance at the Korea Centers for Disease Control and Prevention.

But the bite risk by a female Anopheles sinensis, the only type of mosquito that transmits malaria, is highest north of Seoul, said Kweon and Dr. Terry Klein, a recently retired Army colonel who is now the U.S. military’s regional emerging infectious disease consultant.

Although temperatures have dipped this week, mosquitoes will be around until the country experiences its first frost, Klein said.

Most mosquitoes that people see here, especially in urban environments, are the common brown mosquito. They pose no threat of disease, Klein said.

“At the end of the season every year, mosquitoes inside the house are more abundant,” Klein said. “They are searching for a warm place to rest.”

Despite the Seoul public health institute’s findings, U.S. servicemembers have been lucky. No one has reported a case of malaria on a U.S. installation within the past few weeks, Klein said.

However, the risk remains, especially for Area I troops.

There are two forms of parasitic malaria strains found in South Korea. One finds its way out of the liver within 12 to 20 days; the other lays dormant for six to nine months before causing symptoms, Klein said.

Malaria’s symptoms can mimic more common illnesses, Klein said. Fever, chills and other symptoms may subside after a day or two but reappear after a few days.

It’s critical for people with such symptoms to tell their doctor where they have been within the last year, Klein said. For example, one military patient diagnosed with malaria last month probably contracted it while in Honduras, Klein said.

People can reduce their exposure to malaria and mosquitoes by wearing long sleeves and pants, especially at dusk; by removing any standing water, which acts as a mosquito breeding ground; and by using mosquito repellent with a 33 percent concentration of DEET.

WHO: More Investment in TB Tests Needed
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GENEVA — Industry investment to improve tuberculosis testing would better use the $1 billion spent each year on TB diagnostics to track down the disease that kills 1.7 million people each year, health officials said Wednesday.

Millions of people infected with TB go undiagnosed because high-tech and rapid diagnostics are scarce in Third World countries where three-quarters of the tests for the disease are carried out, according to a report by the World Health Organization on the global market for TB diagnostics.

"We're dealing still with a basic technology, microscopy that is over 100 years old as the fundamental method of diagnosis," particularly in poor countries, said Rob Ridley, director of WHO's tropical disease research program. "There is an urgent need for rapid diagnostic tests that can be used in resource-poor settings," he said. "That has to be done in collaboration with the pharmaceutical industry."

Jane Cunningham, main author of the 203-page report, said that of the estimated 9 million TB cases every year, only 2 million are confirmed by a laboratory diagnosis. Some of the cases are discovered only by inefficient tests or guesswork, allowing the disease to advance in infected individuals and spread to others.

"Rapid and accurate diagnosis of TB is an essential component to TB control," she said.

The 22 high-burden TB countries the report lists include Afghanistan, Brazil, China, India, Kenya and Russia.

In Europe and North America, high-tech molecular and rapid culture tests can provide results within seven to 10 days, but patients in poor countries who rely on traditional microscopic _ or sputum smear _ tests have to wait much longer for the result, Cunningham said.

Giorgio Roscigno, who heads the Geneva-based Foundation for Innovative New Diagnostics, said microscopic tests catch only 50 percent of cases.

"We're spending money on technologies that are inadequate and not very sensitive," Roscigno told reporters.

The WHO report says that industry has only limited interest in TB diagnostics because of lack of information about the market size and its character. Most of the recently developed tests are applied in industrialized countries, where less than 5 percent of worldwide TB cases occur, it says.

"Only three of the top 10 diagnostic manufacturers have TB diagnostics in their product portfolio," said. "This includes Roche, Becton Dickenson and Biomerieux."

According to the report, $1 billion is spent on TB tests every year, while only $300 million is spent on drugs for treatment.

"That same amount of money could be spent on better diagnostic tools if these were available," said Roscigno, who urged the pharmaceutical industry to invest more in public-private partnerships to bring available efficient technology to poor countries and develop new diagnostics. Companies could lower the risk of investment in developing new tools by teaming up with international organizations and public-private foundations, he said.

The cost for developing new diagnostics and adapting existing ones would be "relatively low," the report says.

Cunningham said of the TB diagnostics market _ which includes detection of active TB, detection of latent infection and detection of drug resistant TB _ includes $400 million spent for the supplies to perform the test and $600 million spent on labor costs.

The money used for supplies would be immediately recoverable by the manufacturer if invested in better testing, she said.

The WHO report gives examples of the discrepancy between disease burden and detection ability in different countries. The United States, which has an estimated 13,400 new TB cases per year, has 17,400 laboratories to diagnose the disease or TB drug resistance. But India _ with an estimated 1,788,000 new cases per year _ only has around 21,000 laboratories.

Study says scans could save millions from lung cancer
10/26/06 - By Gina Kolata, The New York Times

Researchers in New York report that millions of lives could be saved by detecting lung cancer early with annual CT scans and treating it immediately, when it can still be cured.

The stakes are high: while death rates for other cancers have fallen, lung cancer is the leading cause of cancer deaths in this country, killing more than 160,000 people a year.

For years, doctors have thought there was little they could do for lung cancer, but now with more sensitive scans, many are rethinking that view.

"You could prevent 80 percent of deaths," said the study's lead author, Dr. Claudia Henschke, a professor of radiology and cardiothoracic surgery at Weill Cornell Medical College.

But the report is controversial. Some medical experts and a patient advocacy group say that because this study is so much bigger than previous studies and so carefully done, it should change the testing landscape, while others say that it did not include comparison groups to demonstrate clearly that there is any benefit from annual CT exams.

The study, by researchers at NewYork-Presbyterian/Weill Cornell hospital and published today in The New England Journal of Medicine, involved more than 31,000 people in seven countries. The participants included smokers and former smokers, but also included people in Japan who had never smoked but had the scans as part of annual physical exams.

The scans found 484 lung cancers, 412 of which were at a very early stage. Then the researchers tracked those cancer patients for an average of about three years after the cancer was detected. After three years, most patients were still alive. The researchers projected that more than 80 percent of those with early-stage cancer would live at least 10 years after their cancer was diagnosed.

Supporters of the findings include Dr. James Mulshine, a professor of internal medicine at Rush University Medical Center in Chicago. The study design may not have been perfect, he said, and there is more to be learned from other studies that are now under way, but he said the data from this one was convincing.

"This is a profoundly important report," Dr. Mulshine said. "It is a remarkable result."

Members of an advocacy group for lung cancer patients, the Lung Cancer Alliance, agreed. "This is the most important breakthrough for the lung cancer community," Laurie Fenton, the group's president, said in a news release.

And, says Dr. Henschke's colleague Dr. David Yankelevitz, it makes sense that early detection can save lives. Lung cancer screening is analogous to screening for breast cancer, Dr. Yankelevitz said. In both situations, he added, "treatment is easier and the outcomes are better when the tumor is small."

But mammograms are endorsed by many national groups, whereas lung cancer screening is not. And while praising the new study's careful accumulation of data, representatives of groups like the American Cancer Society, the American Society of Clinical Oncology, the International Association for the Study of Lung Cancer and the U.S. Preventive Services Task Force, say the study is unlikely to persuade them to recommend screening as a public policy.

One reason is that everyone in Dr. Henschke's study had CT scans. And so, researchers say, with no comparison group of people who did not have scans, they are left wondering: Does screening, in the end, save lives?

"Intuitively, it makes sense," said Dr. Stephen Swensen, a professor of radiology at the Mayo Clinic who conducted a study that was similar to Dr. Henschke's but smaller.

Dr. Swensen added, "It makes sense that if you find a cancer earlier you will save lives."

But "the science hasn't backed that up yet," he said.

Cancer specialists have long known that there are cancers of all types - and lung cancers are no exception - that stop growing on their own, or that grow so slowly that they never cause problems. So, some ask, how many of the people said to be cured were never in danger? And how often will people have operations that can involve removing part of a lung, which is risky in itself, when their cancer was not lethal?

The problem, as with other cancer scans, is that science cannot always tell the difference between cancers that will stop and those that will not.

The researchers also ask another question: How often did the scans find cancers early but without affecting the person's life expectancy?

"Everyone knows we can pick up things better with screening," said Dr. Elliott Fishman, a professor of radiology and oncology at Johns Hopkins Hospital in Baltimore. "But is picking up the same thing as curing? If I pick up a tumor that is one centimeter today and you live five years or I pick it up four years later and you live one year, it's the same thing."

Even evaluating patients with suspicious CT results can be risky, more dangerous, say, than evaluating women with suspicious lumps on a mammogram, said Dr. David Johnson, deputy director of the cancer center at Vanderbilt University and a past president of the American Society of Clinical Oncology.

In Dr. Henschke's study, doctors investigated more than 4,000 nodules in patients, finding about 400 early-stage cancers.

"This is not sticking a needle in a breast," Dr. Johnson said. "It is sticking a needle in the chest, where it can collapse a lung." In some cases, that is followed by surgery to further evaluate a lump. "How many people do we subject to needless evaluations?" Dr. Johnson asked.

It is not even clear, some researchers said, whether the patients in Dr. Henschke's study really would survive 10 years on average. The investigators used a statistical model to estimate how long patients would be expected to live after most had survived about three years.

"Ten years should be 10 years," Dr. Fishman said. "It's being guesstimated out. Let's look in 10 years and see what happens."

More definitive answers about the value of CT testing may come in a few years when another study, by the National Cancer Institute, is over. It randomly assigned its nearly 55,000 participants, smokers or former smokers, to have annual CT scans or, for comparison, chest X-rays. Based on previous studies, many researchers consider chest X-rays largely ineffective for early diagnosis of the cancer, so it can serve as a placebo control in this study.

Another institute study is assessing chest X-rays by randomly assigning participants to have an annual X-rays or to have no screening.

In the meantime, cancer specialists say doctors and their patients must decide, on an individual basis, what to do. They could wait for the clinical trials to be completed, or they could decide to

have scans now, while the data may not be ideal.

And the scans can be expensive. Dr. Howard Forman, a professor of diagnostic radiology at Yale, says that Yale charges $802.39 for the scan and the doctor's interpretation.

And while many insurers do not pay for CT lung cancer screening tests, that may change, Dr. Forman said. He said he did not find this study to be convincing - like others, he said he needed to see control group data. But Dr. Forman, who is on the Medical Policy and Technology Assessment Committee for Wellpoint, an insurance company, said it would be hard to deny paying for the test now that the data were in The New England Journal of Medicine.

"The New England Journal of Medicine is a de facto Good Housekeeping seal of approval," Dr. Forman said.

"It is not proof that screening saves lives," he said. But, he added, "proof for a lot of medicine is not there."

For now, said Dr. Robert Smith, director of cancer screening at the American Cancer Society, it may make sense for smokers or former smokers to have scans for early lung cancer detection.

Patients, Dr. Smith added, should discuss the test with their doctors first, going over potential benefits and potential dangers. And they should be careful to go to a center that has the expertise and experience to do the scans and any follow-up medical procedures properly.

But, he said, the new study adds to the information that CT scans might save lives.

"There is a lot of promise here," he said. And so, he said, "it is not at all unreasonable for individuals at high risk of lung cancer to seek testing on their own."

Others, like Dr. Ned Patz, a professor of radiology, pharmacology and cancer biology at Duke University Medical Center, say they suspect that patients' desire for the tests may cool once they know of the risks.

"A lot of patients ask about it," Dr. Patz said. "We counsel them and tell them what the data are. Then they are not interested."